

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
HOSPITAL INPATIENT**

**MANUAL ABSTRACT REPORTING FORM  
Effective with Discharges on or after October 1, 2015**

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements  
(Title 22, Sections 97216 through 97234)

<b>TYPE OF CARE</b> 1 Acute      5 Chem Dep <input type="checkbox"/> 3 SN/IC     6 Physical Rehab 4 Psychiatric	<b>FACILITY ID NUMBER</b> <input style="width:100%; height: 20px;" type="text"/>	<b>ABSTRACT RECORD NUMBER (Optional)</b> <input style="width:100%; height: 20px;" type="text"/>
--	---	--

<b>DATE OF BIRTH</b> <input style="width:100%; height: 20px;" type="text"/> <i>Month   Day   Year ( 4 - Digit )</i>	<b>PATIENT'S SOCIAL SECURITY NUMBER</b> <input style="width:100%; height: 20px;" type="text"/> <i>Report 000 00 0001 if SSN is Unknown</i>	<b>SEX</b> 1 Male      3 Other <input type="checkbox"/> 2 Female    4 Unknown
---	--	---

<b>ETHNICITY</b> 1 Hispanic <input type="checkbox"/> 2 Non-Hispanic 3 Unknown	<b>RACE</b> 1 White                      4 Asian/Pacific <input type="checkbox"/> 2 Black                      Islander 3 Native American/    5 Other Eskimo/Aleut          6 Unknown	<b>ZIP CODE</b> <input style="width:100%; height: 20px;" type="text"/> <i>XXXXX=Unknown YYYYY=Foreign ZZZZZ=Homeless</i>
--	---	--

<b>ADMISSION DATE</b> <input style="width:100%; height: 20px;" type="text"/> <i>Month   Day   Year (4 - Digit)</i>	<b>DISCHARGE DATE</b> <input style="width:100%; height: 20px;" type="text"/> <i>Month   Day   Year (4 - Digit)</i>	<b>TOTAL CHARGES</b> <input style="width:100%; height: 20px;" type="text"/> <i>(Report whole dollars only, right justified)</i>
--	--	---

<b>SOURCE OF ADMISSION</b> SITE 1 Home                      7 Newborn 2 Residential Care Facility    8 Prison/Jail 3 Ambulatory Surgery       9 Other <input type="checkbox"/> 4 SN/IC 5 Acute <u>Inpatient</u> Hospital Care 6 Other <u>Inpatient</u> Hospital Care	LICENSURE OF SITE 1 This Hospital 2 Another Hospital <input type="checkbox"/> 3 Not a Hospital	ROUTE 1 <u>Your</u> ER 2 Not <u>Your</u> ER (or no ER) <input type="checkbox"/>
---	---	--

<b>TYPE OF ADMISSION</b> 1 Scheduled 2 Unscheduled 3 Infant, under 24 hrs old <input type="checkbox"/> 4 Unknown	<b>PREHOSPITAL CARE AND RESUSCITATION</b> DNR orders at admission or within 24 hrs of admission  Y = Yes <input type="checkbox"/> N = No
--	--

<b>EXPECTED SOURCE OF PAYMENT</b> PAYER CATEGORY 01 Medicare 02 Medi-Cal <input style="width:20px; height: 20px;" type="text"/> 03 Private Coverage 04 Workers' Compensation 05 County Indigent Programs 06 Other Government 07 Other Indigent 08 Self Pay 09 Other Payer	TYPE OF COVERAGE 1 Managed Care - Knox - Keene/ MCOHS <input type="checkbox"/> 2 Managed Care - Other 3 Traditional Coverage	NAME OF PLAN <input style="width:100%; height: 20px;" type="text"/> (0001 - 9999 Plan Code Number)
---	---	--

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
HOSPITAL INPATIENT

MANUAL ABSTRACT REPORTING FORM  
Effective with Discharges on or after October 1, 2015

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements  
(Title 22, Sections 97216 through 97234)

DISPOSITION OF PATIENT

--	--

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to a short term general hospital for inpatient care
- 03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care
- 04 Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility)
- 05 Discharged/transferred to a designated cancer center or children's hospital
- 06 Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care
- 07 Left against medical advice or discontinued care
- 20 Expired
- 21 Discharged/transferred to court/law enforcement
- 43 Discharged/transferred to a federal health care facility
- 50 Hospice - Home
- 51 Hospice - Medical facility (certified) providing hospice level of care
- 61 Discharged/transferred to a hospital-based Medicare approved swing bed
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including a rehabilitation distinct part units of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 Discharged/transferred to a Critical Access Hospital (CAH)
- 69 Discharged/transferred to a designated Disaster Alternative Care Site
- 70 Discharged/transferred to another type of health care institution not defined elsewhere in this code list
- 81 Discharged to home or self care with a planned acute care hospital inpatient readmission
- 82 Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission
- 83 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission
- 84 Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility) with a planned acute care hospital inpatient readmission
- 85 Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
- 86 Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
- 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
- 88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
- 90 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital with a planned acute care hospital inpatient readmission
- 91 Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission
- 92 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal) but not certified under Medicare with a planned acute care hospital inpatient readmission
- 93 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
- 94 Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission
- 95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission
- 00 Other



MANUAL ABSTRACT REPORTING FORM

Effective with Discharges on or after October 1, 2015

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97216 through 97234)

**PRINCIPAL DIAGNOSIS**

--	--	--	--	--	--	--	--	--	--

**PRESENT ON ADMISSION**

Y = Yes  
 N = No  
 U = Unknown  
 W = Clinically Undetermined  
 blank = Exempt from POA reporting (1 or E also accepted)

**OTHER DIAGNOSES**

a.									
b.									
c.									
d.									
e.									
f.									
g.									
h.									
i.									
j.									
k.									
l.									

**PRESENT ON ADMISSION**


m.									
n.									
o.									
p.									
q.									
r.									
s.									
t.									
u.									
v.									
w.									
x.									

**PRINCIPAL PROCEDURE AND DATE**

										Month	Day	Year (4-Digit)							

**OTHER PROCEDURES AND DATES**

a.																			
b.																			
c.																			
d.																			
e.																			
f.																			
g.																			
h.																			
i.																			
j.																			
k.																			
l.																			
m.																			
n.																			
o.																			
p.																			
q.																			
r.																			
s.																			
t.																			

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
HOSPITAL INPATIENT**

**MANUAL ABSTRACT REPORTING FORM  
Effective with Discharges on or after January 1, 2015**

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements  
(Title 22, Sections 97216 through 97234)

<b>TYPE OF CARE</b> 1 Acute      5 Chem Dep <input type="checkbox"/> 3 SN/IC      6 Physical Rehab 4 Psychiatric	<b>FACILITY ID NUMBER</b> <input style="width:100%; height: 20px;" type="text"/>	<b>ABSTRACT RECORD NUMBER (Optional)</b> <input style="width:100%; height: 20px;" type="text"/>
---	---	--

<b>DATE OF BIRTH</b> <input style="width:100%; height: 20px;" type="text"/> <i>Month   Day   Year ( 4 - Digit )</i>	<b>PATIENT'S SOCIAL SECURITY NUMBER</b> <input style="width:100%; height: 20px;" type="text"/> <i>Report 000 00 0001 if SSN is Unknown</i>	<b>SEX</b> 1 Male      3 Other <input type="checkbox"/> 2 Female    4 Unknown
---	--	---

<b>ETHNICITY</b> 1 Hispanic <input type="checkbox"/> 2 Non-Hispanic 3 Unknown	<b>RACE</b> 1 White      4 Asian/Pacific <input type="checkbox"/> 2 Black      Islander 3 Native American/    5 Other Eskimo/Aleut      6 Unknown	<b>ZIP CODE</b> <input style="width:100%; height: 20px;" type="text"/> <i>XXXXX=Unknown YYYYY=Foreign ZZZZZ=Homeless</i>
--	---	--

<b>ADMISSION DATE</b> <input style="width:100%; height: 20px;" type="text"/> <i>Month   Day   Year (4 - Digit)</i>	<b>DISCHARGE DATE</b> <input style="width:100%; height: 20px;" type="text"/> <i>Month   Day   Year (4 - Digit)</i>	<b>TOTAL CHARGES</b> <input style="width:100%; height: 20px;" type="text"/> <i>(Report whole dollars only, right justified)</i>
--	--	---

<b>SOURCE OF ADMISSION</b> SITE 1 Home      7 Newborn 2 Residential Care Facility    8 Prison/Jail 3 Ambulatory Surgery      9 Other <input type="checkbox"/> 4 SN/IC 5 Acute <u>Inpatient</u> Hospital Care 6 Other <u>Inpatient</u> Hospital Care	LICENSURE OF SITE 1 This Hospital <input type="checkbox"/> 2 Another Hospital 3 Not a Hospital	ROUTE 1 <u>Your</u> ER 2 Not <u>Your</u> ER (or no ER) <input type="checkbox"/>
--	---	--

<b>TYPE OF ADMISSION</b> 1 Scheduled 2 Unscheduled 3 Infant, under 24 hrs old <input type="checkbox"/> 4 Unknown	<b>PREHOSPITAL CARE AND RESUSCITATION</b> DNR orders at admission or within 24 hrs of admission  Y = Yes <input type="checkbox"/> N = No
--	--

<b>EXPECTED SOURCE OF PAYMENT</b> PAYER CATEGORY 01 Medicare 02 Medi-Cal <input style="width:20px; height: 20px;" type="text"/> 03 Private Coverage 04 Workers' Compensation 05 County Indigent Programs 06 Other Government 07 Other Indigent 08 Self Pay 09 Other Payer	TYPE OF COVERAGE 1 Managed Care - Knox - Keene/ MCOHS <input type="checkbox"/> 2 Managed Care - Other 3 Traditional Coverage	NAME OF PLAN <input style="width:100%; height: 20px;" type="text"/> (0001 - 9999 Plan Code Number)
---	---	--

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
HOSPITAL INPATIENT

MANUAL ABSTRACT REPORTING FORM  
Effective with Discharges on or after January 1, 2015

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements  
(Title 22, Sections 97216 through 97234)

DISPOSITION OF PATIENT

--	--

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to a short term general hospital for inpatient care
- 03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care
- 04 Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility)
- 05 Discharged/transferred to a designated cancer center or children's hospital
- 06 Discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care
- 07 Left against medical advice or discontinued care
- 20 Expired
- 21 Discharged/transferred to court/law enforcement
- 43 Discharged/transferred to a federal health care facility
- 50 Hospice - Home
- 51 Hospice - Medical facility (certified) providing hospice level of care
- 61 Discharged/transferred to a hospital-based Medicare approved swing bed
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including a rehabilitation distinct part unit of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 Discharged/transferred to a Critical Access Hospital (CAH)
- 69 Discharged/transferred to a designated Disaster Alternative Care Site
- 70 Discharged/transferred to another type of health care institution not defined elsewhere in this code list
- 81 Discharged to home or self care with a planned acute care hospital inpatient readmission
- 82 Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission
- 83 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission
- 84 Discharged/transferred to a facility that provides custodial or supportive care (includes Intermediate Care Facility) with a planned acute care hospital inpatient readmission
- 85 Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
- 86 Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission
- 87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission
- 88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission
- 89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
- 90 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital with a planned acute care hospital inpatient readmission
- 91 Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission
- 92 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal) but not certified under Medicare with a planned acute care hospital inpatient readmission
- 93 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
- 94 Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission
- 95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission
- 00 Other



MANUAL ABSTRACT REPORTING FORM

Effective with Discharges on or after January 1, 2015

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements (Title 22, Sections 97216 through 97234)

**PRINCIPAL DIAGNOSIS**

--	--	--	--	--	--	--	--	--	--

**PRESENT ON ADMISSION**

Y = Yes

N = No

U = Unknown

W = Clinically Undetermined

blank = Exempt from POA reporting (1 or E also accepted)

**OTHER DIAGNOSES**

a.									
b.									
c.									
d.									
e.									
f.									
g.									
h.									
i.									
j.									
k.									
l.									

**PRESENT ON ADMISSION**


m.									
n.									
o.									
p.									
q.									
r.									
s.									
t.									
u.									
v.									
w.									
x.									


**PRINCIPAL PROCEDURE AND DATE**

--	--	--	--	--	--	--	--

Month		Day		Year (4-Digit)					

**OTHER PROCEDURES AND DATES**

a.																			
b.																			
c.																			
d.																			
e.																			
f.																			
g.																			
h.																			
i.																			
j.																			

k.																			
l.																			
m.																			
n.																			
o.																			
p.																			
q.																			
r.																			
s.																			
t.																			

# OSHPD Office of Statewide Health Planning and Development

**Patient Data Section, Healthcare Information Division**

400 R Street, Suite 270

Sacramento, California 95811-6213

(916) 326-3935 Fax (916) 327-1262

www.oshpd.ca.gov



## Agent Designation Form

In order to designate a third party agent to submit data on your behalf, your facility must complete this form. All information must be provided, including a signature from a facility administrator or primary contact.

*Please print clearly*

### Section 1: Facility Information *(all information is required)*

1. FACILITY ID NUMBER:	2. FACILITY NAME:
3. DATA TYPE(S): <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Department <input type="checkbox"/> Ambulatory Surgery Check one or more Data Type(s). <i>If none are checked, the Agent will be given access to all Data Types associated with your facility.</i>	
4. FACILITY BUSINESS ADDRESS (MAILING ADDRESS):	
5. FACILITY CONTACT NAME:	6. TITLE:
7. PHONE:	8. E-MAIL ADDRESS:

### Section 2: Designated Agent Information *(all information is required)*

9. NAME OF DESIGNATED AGENT (COMPANY NAME):	
10. BUSINESS ADDRESS (MAILING ADDRESS):	
11. CONTACT NAME:	
12. PHONE:	13. E-MAIL ADDRESS:
<b>DESIGNATION EFFECTIVE DATE</b>	
14. EFFECTIVE REPORT PERIOD BEGIN DATE:	Designation is effective until OSHPD receives written notification of revocation or new designation.

By signing this document, I certify that I am an official of my facility and I am approving the aforementioned Designated Agent to submit data on behalf of my facility for the designated data type(s) and effective date.

15. NAME (PRINT):	16. TITLE:
17. SIGNATURE:	18. DATE:

**OSHHPD** Office of Statewide Health Planning and Development

*Patient Data Section, Healthcare Information Division*  
400 R Street, Suite 270  
Sacramento, California 95811-6213  
(916) 326-3935 Fax (916) 327-1262  
www.oshpd.ca.gov



**PATIENT DATA REPORTING  
EXTENSION REQUEST**

**Fax Request to: (916) 322-9555**  
Or (916) 327-1262  
Attn: Patient Data Section

Date: \_\_\_\_\_

1. Facility Name: \_\_\_\_\_

2. Facility Identification Number: \_\_\_\_\_

3. Address: \_\_\_\_\_

4. Data Type:

<input type="checkbox"/> Inpatient
<input type="checkbox"/> Emergency Department
<input type="checkbox"/> Ambulatory Surgery

5. Report Period Begin Date: \_\_\_\_\_

6. Report Period End Date: \_\_\_\_\_

7. Designated Agent (if applicable): \_\_\_\_\_

8. Number of Extension Days Requested: \_\_\_\_\_

9. Person Requesting Extension (print): \_\_\_\_\_

10. Signature: \_\_\_\_\_

11. Title: \_\_\_\_\_

12. Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

# User Account Administrator (UAA) Agreement

*Please print clearly*

## Section 1: MIRCAl User Account Administrator Information (all information is required)

1. FACILITY ID NUMBER:		2. FACILITY NAME:	
3. NAME (FIRST, MIDDLE INITIAL, LAST AND CREDENTIALS):			
4. POSITION (TITLE):		5. SUPERVISOR NAME:	
6. BUSINESS ADDRESS (MAILING ADDRESS):		7. UNIQUE EMPLOYEE IDENTIFIER : <i>Note: An identifier that uniquely distinguishes you within your organization.</i>	
8. BUSINESS PHONE:		9. BUSINESS FAX:	
10. E-MAIL ADDRESS:			
11. AUTHENTICATION WORDS: Remember these words. You may be asked to identify yourself with this information if you call to reset your password.			
a. Your mother's maiden name:		b. Your city of birth:	
<p>I understand that as an appointed MIRCAl User Account Administrator on behalf of the facility, I have the responsibility to:</p> <ol style="list-style-type: none"> <li>1. Create/add and inactivate user accounts for other MIRCAl users within my facility. Creating a user account includes granting access roles for an individual to read, submit and/or correct my facility's confidential data. Removing granted access roles and/or inactivating user accounts revokes this access.</li> <li>2. Modify the demographic information for my facility's Primary, Secondary and Administrator Contacts. This notifies OSHPD of any changes in name, mailing address, phone number, and e-mail address for each contact. Modifying contact demographic information directly changes the information on the OSHPD database.</li> <li>3. Change passwords for MIRCAl users within my facility. In the event that a user misplaces or forgets their password, they will be directed to contact their User Account Administrator to have it reset. The User Account Administrator should authenticate the user prior to resetting the password and issuing a new password.</li> <li>4. Unlock MIRCAl user accounts. MIRCAl will lock user accounts after three (3) unsuccessful log on attempts. When the account is locked, users will be required to contact their User Account Administrator to unlock their account.</li> <li>5. Reactivate inactive accounts. NOTE: After 270 consecutive days (9 months) of inactivity, MIRCAl user accounts may be inactivated.</li> </ol> <p>By signing this document I acknowledge reading, understanding, and agreeing to its contents.</p>			
12. USER ACCOUNT ADMINISTRATOR SIGNATURE:		13. DATE:	

## Section 2: Facility Administrator Approval (all information is required) To be completed by the Facility Administrator (CEO or equivalent)

14. FACILITY ADMINISTRATOR NAME:		15. FACILITY ADMINISTRATOR SIGNATURE:	
16. DATE:		17. PHONE NUMBER:	

The completed form shall be sent to OSHPD for each User Account Administrator needing MIRCAl UAA access. Fax (916) 327-1262 or (916) 322-9555

## Section 3: For OSHPD use only

Date Received:	Date Authenticated/Enrolled:	By:
User Name:	Note:	

## *User Account Administrator (UAA) Agreement Instructions*

Make a copy of the completed forms for your records. Send the *completed form(s)* to:

Office of Statewide Health Planning and Development  
Patient Data Section  
400 R Street, Suite 270  
Sacramento, CA 95811-6213  
www.oshpd.ca.gov/HID/MIRCal/

Contact Information  
Call your OSHPD Analyst or (916) 326-3920  
E-mail [mircal@oshpd.ca.gov](mailto:mircal@oshpd.ca.gov)  
Fax (916) 327-1262 or (916) 322-9555

### **SECTION 1: MIRCal User Account Administrator Information (All fields must be completed) -- *To be completed by the prospective MIRCal User Account Administrator.***

1. Facility ID Number: Provide your OSHPD assigned 6 digit facility number.
2. Facility Name: Provide the licensed name of your facility.
3. Name and Credentials: Provide your full name and credentials (if applicable).
4. Position (Title): Provide the position held at your facility.
5. Supervisor Name: Provide the name of your supervisor/manager.
6. Business Address (Mailing Address): Enter the business address where you can receive mail.
7. Unique Employee Identifier: Provide an identifier that your facility uses that uniquely distinguishes you from other employees within your organization. (I.e. title, badge number, employee number, etc.)
8. Business Phone: Provide a phone number where you can be contacted.
9. Business Fax: Provide a fax number where you can receive faxes.
10. E-mail address: Provide an e-mail address where you can be contacted.
11. Authentication Words: The authentication words provided may be used to identify you in the event that a password reset is required. It is important to remember this information.
  - a. Provide your mother's maiden name.
  - b. Provide your city of birth.
12. User Account Administrator Signature: If you acknowledge reading, understanding and agreeing to the contents of this document, provide your signature.
13. Date: Provide the date that the facility agreement was completed and signed.

### **SECTION 2: Facility Administrator Approval (All fields must be completed) – *To be completed by the Facility Administrator (CEO or equivalent). This should be the person who directs the overall management of the facility. OSHPD will cross reference this name against the name supplied by your facility as the MIRCal Facility Administrator contact person.***

14. Facility Administrator Name: Print your name.
15. Facility Administrator Signature: After you have reviewed and approved the completed Facility User Account Administrator Agreement, you must provide your signature indicating approval of person to act as the MIRCal User Account Administrator.
16. Date: Date of signature.
17. Phone Number: Provide a phone number where you can be reached.

### ***SECTION 3: For OSHPD Use Only***

# Designated Agent User Agreement

*Please print clearly*

**Section 1: MIRCAl Designated Agent User Information (all information is required)**

1. DESIGNATED AGENT NAME	
2. NAME OF MIRCAl DESIGNATED AGENT USER (FIRST, MIDDLE INITIAL, LAST AND CREDENTIALS):	
3. POSITION (TITLE):	4. SUPERVISOR NAME:
5. BUSINESS ADDRESS (MAILING ADDRESS):	6. UNIQUE EMPLOYEE IDENTIFIER: <small>Note: An identifier that uniquely distinguishes you within your organization.</small>
7. BUSINESS PHONE:	8. BUSINESS FAX:
9. E-MAIL ADDRESS:	
10. AUTHENTICATION WORDS: Remember these words. You may be asked to identify yourself with this information if you call to reset your password.	
a. Your mother's maiden name:	b. Your city of birth:
<p>I understand that as a Designated Agent User:</p> <ol style="list-style-type: none"> <li>1. I can submit data and retrieve the status of the data on behalf of a facility.</li> <li>2. My MIRCAl user account may be inactivated after 270 consecutive days (9 months) of inactivity. Only OSHPD can reactivate my account.</li> </ol> <p>By signing this document I acknowledge reading, understanding, and agreeing to its contents.</p>	
11. DATE:	12. USER SIGNATURE:

**Section 2: Designated Agent Primary Contact Approval (all information is required)**

13. PRINT NAME:	14. DESIGNATED AGENT "PRIMARY" CONTACT SIGNATURE:
15. DATE:	16. PHONE NUMBER:

The completed form shall be sent to OSHPD for each Designated Agent user needing MIRCAl access. Fax (916) 327-1262 or (916) 322-9555

**Section 3: For OSHPD use only**

Date Received:	Date Authenticated/Enrolled:	By:
User Name:	Note:	

*Please Note: The Facility Administrator or Primary Contact at each facility that you represent must complete and sign the Agent Designation Form (OSHPD 1370.3) approving a Designated Agent to submit data on their behalf.*

## *Designated Agent User Agreement Instructions*

Make a copy of the completed forms for your records. Send the *completed form(s)* to:

Office of Statewide Health Planning and Development  
Patient Data Section  
400 R Street, Suite 270  
Sacramento, CA 95811-6213  
www.oshpd.ca.gov/HID/MIRCal/

Contact Information  
Call your OSHPD Analyst or (916) 326-3920  
E-mail [mircal@oshpd.ca.gov](mailto:mircal@oshpd.ca.gov)  
Fax (916) 327-1262 or (916) 322-9555

### *SECTION 1: MIRCal Designated Agent User Information (All fields must be completed) -- To be completed by MIRCal User requesting access to MIRCal.*

1. Name of Designated Agent: Provide the name of your business.
2. Name and Credentials of MIRCal Designated Agent User: Provide the full name of the MIRCal user and credentials (if applicable).
3. Position (Title): Provide the position held in your organization.
4. Supervisor Name: Provide the name of your supervisor/manager.
5. Business Address (Mailing Address): Enter the business address where you can receive mail.
6. Unique Employee Identifier: Provide an identifier that your facility uses that uniquely distinguishes you from other employees within your organization. (I.e. title, badge number, employee number, etc.)
7. Business Phone: Provide a phone number where you can be contacted.
8. Business Fax: Provide a fax number where you can receive faxes.
9. E-mail address: Provide an e-mail address where you can be contacted.
10. Authentication Words: *Remember these words. You may be asked to identify yourself with this information if you call to reset your password.*
  - a. Provide your mother's maiden name.
  - b. Provide your city of birth.
11. Date: Provide the date that the facility agreement was completed and signed.
12. User Signature: If you understand and agree with the responsibilities and guidelines for maintaining MIRCal security, as detailed in the user agreement, provide your signature.

### *SECTION 2: Designated Agent Primary Contact Approval (All fields must be completed) – To be completed by the Designated Primary Contact.*

13. Print Name: Print the name of the Designated Agent Primary Contact.
14. Designated Agent Primary Contact Signature: When the completed information is reviewed and approved, provide your signature indicating approval of person to use MIRCal.
15. Date: Provide the date that this user agreement was approved and signed.
16. Phone Number: Provide a phone number where you can be reached.

### *SECTION 3: OSHPD Use Only*



## No Data to Report

<b>1. Facility Name:</b> _____						
<b>2. Facility ID Number:</b> <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>						

3. We do not have data to report for the above mentioned facility for the following reason(s):

**a) Hospital Inpatient Care:**

**Report Period: From** \_\_\_\_\_ **to** \_\_\_\_\_

We are not licensed to provide inpatient care effective: \_\_\_\_\_

We are licensed for inpatient care for this report period, but did not have any discharges as defined in Section 97213(a) (1) of the California Code of Regulations.

**b) Emergency Department:**

**Report Period: From** \_\_\_\_\_ **to** \_\_\_\_\_

We are not licensed to provide emergency department care effective: \_\_\_\_\_

We are licensed for emergency department services for this report period, but did not have any encounters as defined in Section 97213(a) (2) of the California Code of Regulations.

**c) Hospital-Based Ambulatory Surgery:**

**Report Period: From** \_\_\_\_\_ **to** \_\_\_\_\_

We did not perform procedures on an outpatient basis in a general operating room, ambulatory surgery room, endoscopy unit or cardiac catheterization laboratory as defined in Section 97213(a) (3) of the California Code of Regulations.

**d) Freestanding Ambulatory Surgery Clinic:**

**Report Period: From** \_\_\_\_\_ **to** \_\_\_\_\_

We are not licensed by the State of California as a surgical clinic effective: \_\_\_\_\_

We are licensed as a surgical clinic, but did not perform ambulatory surgery procedures for this report period, as defined in Section 97213(a) (3) of the California Code of Regulations.

**4. Additional Explanation:** \_\_\_\_\_

\_\_\_\_\_

**5. Submitted by:**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title/Position

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
E-mail

**“SAMPLE”  
RACE/ETHNICITY FORM**

*(Courtesy of Fountain Valley Hospital Regional Medical Center)*

Hospitals are required by law to provide the Office of Statewide Health Planning and Development (**OSHPD**) with information regarding the race and ethnicity of their patient population.

The mission of OSHPD is to plan for and support the development of a healthcare system that meets the current and future healthcare needs of the people of California. In doing so, we ask that you assist us in providing this information by making the most appropriate selection regarding race and ethnicity from the choices listed below:

**ETHNICITY (Select One)**

- \_\_\_\_\_ HISPANIC: A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.
- \_\_\_\_\_ NON-HISPANIC Any possible options not covered in the above category.
- \_\_\_\_\_ UNKNOWN A person who cannot or refuses to declare ethnicity.

**RACE (Select One)**

- \_\_\_\_\_ WHITE A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East.
- \_\_\_\_\_ BLACK A person having origins in or who identifies with any of the black racial groups of Africa.
- \_\_\_\_\_ NATIVE AMERICAN/ESKIMO/ALEUT  
A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.
- \_\_\_\_\_ ASIAN/PACIFIC ISLANDER  
A person having origins in or who identifies with any of the original oriental peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippine Islands, and Samoa.
- \_\_\_\_\_ OTHER Any possible options not covered in the above categories. Includes patients who cite more than one race.
- \_\_\_\_\_ UNKNOWN A person who cannot or refuses to declare race.